Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA ROAD
PASADENA TX 77504

Carrier's Austin Representative Box
#15

Respondent Name

ACE AMERICAN INSURANCE CO

MFDR Date Received

NOVEMBER 2, 2007

MFDR Tracking Number

M4-08-1498-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated October 29, 2007: "The Carrier did not make a legal denial of reimbursement because Vista was not provided with a sufficient explanation or the proper denial reasons to justify the denial of reimbursement for the disputed charges. In addition, the Carrier applied the incorrect reimbursement methodology to Vista's charges." "Carrier may reimburse at a 'per diem' rate for the hospital services if the total audited charges for the entire admission are below $40,000, after the Carrier audits the bill pursuant to the applicable rules."

Requestor's Supplemental Position Summary Dated February 15, 2013: "Please allow this letter to serve as a supplemental statement to Vista's originally submitted request for dispute resolution in consideration of the Texas Third Court of Appeals' Final Judgment…The medical records on file with MDR and the additional records attached hereto, show this admission to be a complex spine surgery specifically a one-level lumbar interbody fusion at L4-L5 with spinal instrumentation, including a cage, and bone graft. This complex spine surgery is unusually extensive for a least two reasons…The medical and billing records on file with MDR and additional records attached hereto, also show that this admission was unusually costly for two reasons."

Amount in Dispute: $75,550.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated November 21, 2007: "The Requestor seeks additional reimbursement under the Acute Care Inpatient Hospital Fee Guidelines. The Requestor has invoked the Stop-Loss provision of Rule 134.401 and seeks additional reimbursement in the amount of $75,550.47 for a two-day surgery consisting of a spinal surgery. The Provider/Requestor billed $117,633.84, and the Respondent paid $12,533.25 for dates of service June 27, 2007 through June 28, 2007…Respondent maintains that it paid a fair and reasonable rate for the services provided."

Response Submitted by: Harris & Harris

Respondent's Supplemental Position Summary Dated February 26, 2013: "In short summary, an unremarkable hospital stay involving the exact services anticipated and nothing beyond routine post-operative care, by definition, does not trigger or qualify for reimbursement per the stop-loss exception. The 'unusually extensive' element of stop loss is nowhere to be found. The hospital has been paid correctly under the 1997 hospital in-patient fee guideline. No additional payment is due."

Response Submitted by: Downs-Stanford, PC

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
June 27, 2007 through June 28, 2007	Inpatient Hospital Services	$75,550.47	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.240, 31 *Texas Register* 3544, effective May 2, 2006, sets out the procedures for medical payments and denials.
2. 28 Texas Administrative Code §133.2, 31 *Texas Register* 3544, effective May 2, 2006, sets out the definition of final action.
3. 28 Texas Administrative Code §133.305 and §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
5. 28 Texas Administrative Code §134.1, 31 *Texas Register* 3561, effective May 2, 2006, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- 45-Charges exceed your contracted/legislated fee arrangement. This change to be effective 6/1/07. Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
- 50-These are non-covered services because this is not deemed a medical necessity by the payer. $0.00
- W1-Workers Compensation State Fee Schedule Adjustment $0.00
- W1-Workers Compensation State Fee Schedule Adjustment $1,118.00
- W1-Workers Compensation State Fee Schedule Adjustment $11,797.20
- 100-Any network reduction is in accordance with the network referenced above.
- 112-001-The bill has been reimbursed according to the providers contract with AETNA.
- 873-Reimbursement not recommended. Service(s) items(s) not medically necessary for remedial treatment of the work related injury illness $0.00
- 885-999-Review of this code has resulted in an adjusted reimbursement of $0.00
- 885-999-Review of this code has resulted in an adjusted reimbursement of $1,118.00
- 885-999-Review of this code has resulted in an adjusted reimbursement of $11,797.20
- 900-Based on further review, no additional allowance is warranted.
- 975-410-Copy of provider's invoice used to determine reimbursable amount.
- 975-64- Nurse review in-patient hospital facility supply house.
- 981-Reviewed by Medical Director.
- W4-No additional reimbursement allowed after review of appeal/reconsideration.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 111-011-Coventry contract status indicator 11-negotiated or other pricing.

Issues

1. Did the respondent provide sufficient explanation for denial of the disputed services?
2. Did the audited charges exceed $40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?
5. Does a medical necessity issue exist?
6. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §133.240(a) and (e), 31 Texas Register 3544, effective May 2, 2006, state, in pertinent part, that " (a) An insurance carrier shall take final action after conducting bill review on a complete medical bill…" and "(e) The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division… " Furthermore, 28 Texas Administrative Code §133.2, 31 *Texas Register* 3544, states, in pertinent part "(4) Final action on a medical bill-- (A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or (B) denying a charge on the medical bill." The requestor asserts in its position statement that:

   > "The Carrier did not make a legal denial of reimbursement because Vista was not provided with a sufficient explanation or the proper denial reasons to justify the denial of reimbursement for the disputed charges. In addition, the Carrier applied the incorrect reimbursement methodology to Vista's charges."

   Review of the submitted documentation finds that the explanation of benefits were issued using the division-approved form TWCC 62 and noted payment exception codes "45, 50, W1, 100, 112-001, 873, 885-999, 900, 975-640, 981, W4, 193, and 111-011" for the services in dispute.

   These payment exception codes support an explanation for the reduction of reimbursement based on the Per Diem provision in former 28 Texas Administrative Code §134.401. These reasons support a reduction of the reimbursement amount from the requested stop-loss exception payment reimbursement methodology to the standard per diem methodology amount and provided sufficient explanation to allow the provider to understand the reason(s) for the insurance carrier's action(s). The Division therefore concludes that the insurance carrier has met the requirements of §133.240, and §133.2.

2. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold."

Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $117,633.84. The Division concludes that the total audited charges exceed $40,000.

3. The requestor in its original position statement asserts that "Carrier may reimburse at a 'per diem' rate for the hospital services if the total audited charges for the entire admission are below $40,000, after the Carrier audits the bill pursuant to the applicable rules. However, if the total audited charges for the entire admission are above $40,000, the Carrier shall reimburse using the Stop-Loss Methodology in accordance with the plain language of the rule contained in § 134.401(c)(6)(A)(iii). This rule does not require a hospital to prove that services provided during the admission were unusually extensive or unusually costly to trigger the application of the Stop Loss Methodology. It is presumed that the services provided were unusually extensive or unusually costly when the $40,000 stop-loss threshold is reached." As noted above, the Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) rendered judgment to the contrary. In its supplemental position statement, the requestor considered the Courts' final judgment and opined on both rule requirements. In regards to whether the services were unusually extensive, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually extensive services. Rule §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The requestor's supplemental position statement asserts that:

   > "The medical records on file with MDR and the additional records attached hereto, show this admission to be a complex spine surgery, specifically a one-level lumbar interbody fusion at L4-L5 with spinal instrumentation, including a cage, and bone graft. This complex spine surgery is unusually extensive for at least two reasons: first, this surgery as noted above required extensive spinal instrumentation; and second, this surgery required two surgeons and anesthesia required an arterial line to monitor blood pressure in real time and two large bore IV's during the procedure which is unusually extensive. Further, this procedure required neuromonitoring and a medicine consult to follow the patient post-operatively with management of the hospital stay."

   The requestor did not submit documentation to support the reasons asserted that this spinal surgery was unusually extensive. The reasons stated are therefore not demonstrated. Additionally, the requestor's position that all spinal surgeries are unusually extensive does not satisfy §134.401(c)(2)(C) which requires application of the stop-loss exception on a case-by-case basis. The Third Court of Appeals' November 13, 2008 opinion affirmed this, stating "The rule further states that independent reimbursement under the Stop-Loss Exception will be 'allowed on a case-by-case basis.' *Id.* §134.401(c)(2)(C). This language suggests that the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." The requestor's position that all spine surgeries are unusually extensive fails to meet the requirements of §134.401(c)(2)(C) because the particulars of the services in dispute are not discussed, nor does the requestor demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgery services or admissions. For the reasons stated, the division finds that the requestor failed to demonstrate that the services in dispute were unusually extensive.

4. In regards to whether the services were unusually costly, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor's supplemental position statement asserts that:

   > "The medical and billing records on file with MDR and additional records attached hereto, also show that this admission was unusually costly for two reasons: first, the Medicare outlier threshold amount for this DRG was $86,355.46. Our charges were $117,633.84 for this case. Therefore, this would qualify for additional reimbursement above the DRG reimbursement; and second, it was necessary to purchase expensive implants for use in the surgery, as well as the need for a cell saver during the procedure."

   The requestor asserts that because the ***billed charges*** exceed the stop-loss threshold, the admission in this case is unusually costly. The Division notes that audited charges are addressed as a separate and distinct factor described in 28 Texas Administrative Code §134.401(c)(6)(A)(i). Billed charges for services do not represent the cost of providing those services, and no such relation has been established in the instant case. The requestor fails to demonstrate that the ***costs*** associated with the services in dispute are unusual when

compared to similar spinal surgery services or admissions. For that reason, the division rejects the requestor's position that the admission is unusually costly based on the mere fact that the billed or audited charges "substantially" exceed $40,000. The requestor additionally asserts that certain resources that are used for the types of surgeries associated with the admission in dispute (i.e. specialized equipment and specially-trained, extra nursing staff) added substantially to the cost of the admission. The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for both types of surgeries. Therefore, the requestor fails to demonstrate that the resources used in this particular admission are unusually costly when compared to resources used in other types of surgeries.

5. 28 Texas Administrative Code §134.401(c)(6)(A)(v) states "Audited charges are those charges which remain after a bill review by the insurance carrier has been performed. Those charges which may be deducted are personal items…"

   According to the explanation of benefits, the respondent denied reimbursement for personal items based upon reason code "50". Therefore, these items were denied in accordance with 28 Texas Administrative Code §134.401(c)(6)(A)(v), and a medical necessity issue does not exist in this dispute.

6. 28 Texas Administrative Code §134.401(b)(2)(A) titled General Information states, in pertinent part, that "The basic reimbursement for acute care hospital inpatient services rendered shall be the lesser of:
   (i) a rate for workers' compensation cases pre-negotiated between the carrier and the hospital;
   (ii) the hospital's usual and customary charges; and
   (iii) reimbursement as set out in section (c) of this section for that admission

   In regards to a pre-negotiated rate, the services in dispute were reduced in part with the explanation "45-Charges exceed your contracted/legislated fee arrangement. This change to be effective 6/1/07; 100-Any network reduction is in accordance with the network referenced above; 112-001-The bill has been reimbursed according to the providers contract with AETNA; and 111-011-Coventry contract status indicator 11-negotiated or other pricing." No documentation was provided to support that a reimbursement rate was negotiated between the workers' compensation insurance carrier ACE American Insurance Co. and Vista Hospital of Dallas prior to the services being rendered; therefore 28 Texas Administrative Code §134.401(b)(2)(A)(i) does not apply.

   In regards to the hospital's usual and customary charges in this case, review of the medical bill finds that the health care provider's usual and customary charges equal $117,633.84.

   In regards to reimbursement set out in (c), the division determined that the requestor failed to support that the services in dispute are eligible for the stop-loss method of reimbursement; therefore 28 Texas Administrative Code §134.401(c)(1), titled Standard Per Diem Amount, and §134.401(c)(4), titled Additional Reimbursements, apply. The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

   - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission." The length of stay was one day. The surgical per diem rate of $1,118.00 multiplied by the length of stay of one day results in an allowable amount of $1,118.00.

   - 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)." Review of the requestor's medical bill finds that the following items were billed under revenue code 278 and are therefore eligible for separate payment under §134.401(c)(4)(A):

Code	Itemized Statement Description	UNITS	Cost Per Unit	Cost + 10%
0278	XLIF MAS GRATT	1	$9,831.00	$10,814.10
0278	BONE GRAFT INFUSE	1	No support for cost/invoice	$0.00
			TOTAL ALLOWABLE:	$10,814.10

- 28 Texas Administrative Code §134.401(c)(4)(C) states “Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time.” A review of the submitted itemized statement finds that the requestor billed $346.60/unit for Thrombin USP TOP. The requestor did not submit documentation to support what the cost to the hospital was for these items billed under revenue code 250. For that reason, additional reimbursement for these items cannot be recommended.

The total reimbursement set out in the applicable portions of (c) results in $1,118.00 + $10,814.10, for a total of $11,932.10.

Reimbursement for the services in dispute is therefore determined by the lesser of:

§134.401(b)(2)(A)	Finding
(i)	Not Applicable
(ii)	$117,633.84
(iii)	$11,932.10

The division concludes that application of the standard per diem amount and the additional reimbursements under §134.401(c)(4) represents the lesser of the three considerations. The respondent issued payment in the amount of $12,533.25. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	04/04/2013 Date
Signature	Medical Fee Dispute Resolution Manager	04/04/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.